

Application for a §1915 (c) HCBS Waiver

HCBS Waiver Application Version 3.3

Submitted by:

North Dakota Department of Human Services

Submission Date: December 31, 2006

CMS Receipt Date (CMS Use)

Provide a brief one-two sentence description of the request (e.g., renewal of waiver, request for new waiver, amendment):

Brief Description:

This application is a renewal for the Medicaid Waiver for Home and Community Based Services. The request for renewal includes current Waiver services and additional Waiver services.

State:	North Dakota
Effective Date	October 1, 2007

Application for a §1915(c) Home and Community-Based Services Waiver

PURPOSE OF THE HCBS WAIVER PROGRAM

The Medicaid Home and Community-Based Services (HCBS) waiver program is authorized in §1915(c) of the Social Security Act. The program permits a State to furnish an array of home and community-based services that assist Medicaid beneficiaries to live in the community and avoid institutionalization. The State has broad discretion to design its waiver program to address the needs of the waiver's target population. Waiver services complement and/or supplement the services that are available to participants through the Medicaid State plan and other federal, state and local public programs as well as the supports that families and communities provide.

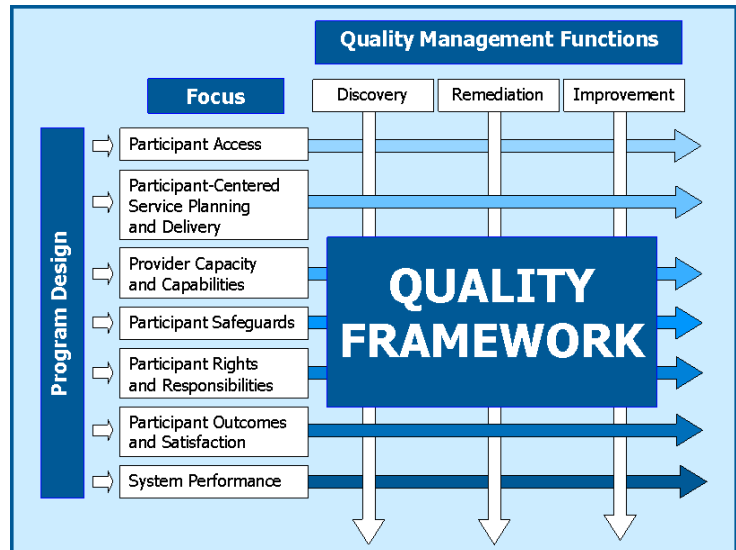
The Centers for Medicare & Medicaid Services (CMS) recognizes that the design and operational features of a waiver program will vary depending on the specific needs of the target population, the resources available to the State, service delivery system structure, State goals and objectives, and other factors. A State has the latitude to design a waiver program that is cost-effective and employs a variety of service delivery approaches, including participant direction of services.

The waiver application is based on the HCBS Quality Framework. The Framework focuses on seven broad, participant-centered desired outcomes for the delivery of waiver services, including assuring participant health and welfare:

- ◆ **Participant Access:** *Individuals have access to home and community-based services and supports in their communities.*
- ◆ **Participant-Centered Service Planning and Delivery:** *Services and supports are planned and effectively implemented in accordance with each participant's unique needs, expressed preferences and decisions concerning his/her life in the community.*
- ◆ **Provider Capacity and Capabilities:** *There are sufficient HCBS providers and they possess and demonstrate the capability to effectively serve participants.*
- ◆ **Participant Safeguards:** *Participants are safe and secure in their homes and communities, taking into account their informed and expressed choices.*
- ◆ **Participant Rights and Responsibilities:** *Participants receive support to exercise their rights and in accepting personal responsibilities.*
- ◆ **Participant Outcomes and Satisfaction:** *Participants are satisfied with their services and achieve desired outcomes.*
- ◆ **System Performance:** *The system supports participants efficiently and effectively and constantly strives to improve quality.*

The Framework also stresses the importance of respecting the preferences and autonomy of waiver participants.

The Framework embodies the essential elements for assuring and improving the quality of waiver services: design, discovery, remediation and improvement. The State has flexibility in developing and implementing a Quality Management Strategy to promote the achievement of the desired outcomes expressed in the Quality Framework.



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1. Request Information

A. The **State** of **North Dakota** requests approval for a Medicaid home and community-based services (HCBS) waiver under the authority of §1915(c) of the Social Security Act (the Act).

B. **Waiver Title** (optional): **Medicaid Waiver for Home and Community Based Services**

C. **Type of Request** (select only one):

<input type="radio"/>	New Waiver (3 Years)	CMS-Assigned Waiver Number (CMS Use):	
<input type="radio"/>	New Waiver (3 Years) to Replace Waiver #		
	CMS-Assigned Waiver Number (CMS Use):		
	<i>Attachment #1 contains the transition plan to the new waiver.</i>		
<input checked="" type="radio"/>	Renewal (5 Years) of Waiver #	0054.90	
<input type="radio"/>	Amendment to Waiver #		

D. **Type of Waiver** (select only one):

<input type="radio"/>	Model Waiver. In accordance with 42 CFR §441.305(b), the State assures that no more than 200 individuals will be served in this waiver at any one time.
<input checked="" type="radio"/>	Regular Waiver, as provided in 42 CFR §441.305(a)

E.1 **Proposed Effective Date:** **April 1, 2007**

E.2 **Approved Effective Date** (CMS Use):

F. **Level(s) of Care.** This waiver is requested in order to provide home and community-based waiver services to individuals who, but for the provision of such services, would require the following level(s) of care, the costs of which would be reimbursed under the approved Medicaid State plan (*check each that applies*):

<input type="checkbox"/>	Hospital (select applicable level of care)
<input type="radio"/>	Hospital as defined in 42 CFR §440.10. If applicable, specify whether the State additionally limits the waiver to subcategories of the hospital level of care:
<input type="radio"/>	Inpatient psychiatric facility for individuals under age 21 as provided in 42 CFR § 440.160
<input checked="" type="checkbox"/>	Nursing Facility (select applicable level of care)
<input checked="" type="radio"/>	As defined in 42 CFR §440.40 and 42 CFR §440.155. If applicable, specify whether the State additionally limits the waiver to subcategories of the nursing facility level of care:
<input type="radio"/>	Institution for Mental Disease for persons with mental illnesses aged 65 and older as provided in 42 CFR §440.140
<input type="checkbox"/>	Intermediate Care Facility for the Mentally Retarded (ICF/MR) (as defined in 42 CFR §440.150). If applicable, specify whether the State additionally limits the waiver to subcategories of the ICF/MR facility level of care:

G. Concurrent Operation with Other Programs. This waiver operates concurrently with another program (or programs) approved under the following authorities (*check the applicable authority or authorities*):

<input type="checkbox"/>	Services furnished under the provisions of §1915(a) of the Act and described in Appendix I		
<input type="checkbox"/>	Waiver(s) authorized under §1915(b) of the Act. <i>Specify the §1915(b) waiver program and indicate whether a §1915(b) waiver application has been submitted or previously approved:</i>		
	Specify the §1915(b) authorities under which this program operates (<i>check each that applies</i>):		
<input type="checkbox"/>	§1915(b)(1) (mandated enrollment to managed care)	<input type="checkbox"/>	§1915(b)(3) (employ cost savings to furnish additional services)
<input type="checkbox"/>	§1915(b)(2) (central broker)	<input type="checkbox"/>	§1915(b)(4) (selective contracting/limit number of providers)
<input type="checkbox"/>	A program authorized under §1115 of the Act. <i>Specify the program:</i>		
X	Not applicable		

2. Brief Waiver Description

Brief Waiver Description. *In one page or less*, briefly describe the purpose of the waiver, including its goals, objectives, organizational structure (e.g., the roles of state, local and other entities), and service delivery methods.

Purpose:

The Medicaid Waiver for Home and Community Based Services provides service options for a continuum of home and community based services in the least restrictive environment.

Goals and Objectives:

The goal is to adequately and appropriately sustain individuals in their own homes and communities and to delay or divert institutional care. In order to successfully meet the mandate, a consumer-centered, affordable delivery system has been established for delivery of in-home services to the elderly and physically disabled.

To accomplish these goals, an array of services is offered through the waiver. A system has been established to assess the needs of consumers, implement a care plan, monitor the progress of the care plan, and re-evaluate consumer needs on a regular basis.

Partnerships:

This system involves a partnership between the local County Social Service Boards, the North Dakota Department of Human Services, informal networks, and consumers/family members. Advocates for consumers have played a significant role in identifying gaps in current Waiver services.

When applicable, other State agencies or other Department of Human Services Divisions have participated in discussions in establishing and maintaining a quality system. They have played a crucial role in the decision making process. Some of the other State agencies and Divisions that have contributed in identifying service needs are: Indian Affairs Commission; Health Department; Minot State University; Protection and Advocacy; ND Department of Human Services Aging Services Division, Developmental Disabilities Division, Division of Mental Health & Substance Abuse, Vocational Rehabilitation, Civil Rights Office, Legal Services Division.

Several non-governmental entities provided input including: AARP, Independent Living Centers, ND Disabilities Consortium, current and potential consumers, family members, and service providers.

Service Delivery System:

The service delivery system includes individual and agency service providers.

The service providers are enrolled through the Department of Human Services, Medical Services Division. The service providers must display skills competency or provide current licensing/credentialing (when applicable).

The case management entities are (local) county social service boards.

Organizational Structure:

The North Dakota Department of Human Services, Medical Services Division is the operating agency and will administer the Waiver.

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3. Components of the Waiver Request

The waiver application consists of the following components. *Note: Item 3-E must be completed.*

- A. Waiver Administration and Operation.** Appendix A specifies the administrative and operational structure of this waiver.
- B. Participant Access and Eligibility.** Appendix B specifies the target group(s) of individuals who are served in this waiver, the number of participants that the State expects to serve during each year that the waiver is in effect, applicable Medicaid eligibility and post-eligibility (if applicable) requirements, and procedures for the evaluation and reevaluation of level of care.
- C. Participant Services.** Appendix C specifies the home and community-based waiver services that are furnished through the waiver, including applicable limitations on such services.
- D. Participant-Centered Service Planning and Delivery.** Appendix D specifies the procedures and methods that the State uses to develop, implement and monitor the participant-centered service plan (of care).
- E. Participant-Direction of Services.** When the State provides for participant direction of services, Appendix E specifies the participant direction opportunities that are offered in the waiver and the supports that are available to participants who direct their services. (*Select one*):

<input checked="checked" type="radio"/>	The waiver provides for participant direction of services. <i>Appendix E is required.</i>
<input type="radio"/>	Not applicable. The waiver does not provide for participant direction of services. <i>Appendix E is not completed.</i>

- F. Participant Rights.** Appendix F specifies how the State informs participants of their Medicaid Fair Hearing rights and other procedures to address participant grievances and complaints.
- G. Participant Safeguards.** Appendix G describes the safeguards that the State has established to assure the health and welfare of waiver participants in specified areas.
- H. Quality Management Strategy.** Appendix H contains the Quality Management Strategy for this waiver.
- I. Financial Accountability.** Appendix I describes the methods by which the State makes payments for waiver services, ensures the integrity of these payments, and complies with applicable federal requirements concerning payments and federal financial participation.
- J. Cost-Neutrality Demonstration.** Appendix J contains the State's demonstration that the waiver is cost-neutral.

4. Waiver(s) Requested

- A. Comparability.** The State requests a waiver of the requirements contained in §1902(a)(10)(B) of the Act in order to provide the services specified in Appendix C that are not otherwise available under the approved Medicaid State plan to individuals who: (a) require the level(s) of care specified in Item 1.F and (b) meet the target group criteria specified in Appendix B.
- B. Income and Resources for the Medically Needy.** Indicate whether the State requests a waiver of §1902(a)(10)(C)(i)(III) of the Act in order to use institutional income and resource rules for the medically needy (*select one*):

<input checked="checked" type="radio"/>	Yes
<input type="radio"/>	No
<input type="radio"/>	Not applicable

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- C. Statewide.** Indicate whether the State requests a waiver of the statewide requirements in §1902(a)(1) of the Act (*select one*):

<input type="radio"/>	Yes (<i>complete remainder of item</i>)
<input checked="" type="radio"/>	No

If yes, specify the waiver of statewide requirements that is requested (*check each that applies*):

<input type="checkbox"/>	Geographic Limitation. A waiver of statewide requirements is requested in order to furnish services under this waiver only to individuals who reside in the following geographic areas or political subdivisions of the State. <i>Specify the areas to which this waiver applies and, as applicable, the phase-in schedule of the waiver by geographic area:</i>
<input type="checkbox"/>	Limited Implementation of Participant-Direction. A waiver of statewide requirements is requested in order to make <i>participant direction of services</i> as specified in Appendix E available only to individuals who reside in the following geographic areas or political subdivisions of the State. Participants who reside in these areas may elect to direct their services as provided by the State or receive comparable services through the service delivery methods that are in effect elsewhere in the State. <i>Specify the areas of the State affected by this waiver and, as applicable, the phase-in schedule of the waiver by geographic area:</i>

5. Assurances

In accordance with 42 CFR §441.302, the State provides the following assurances to CMS:

- A. Health & Welfare:** The State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver. These safeguards include:
- As specified in **Appendix C**, adequate standards for all types of providers that provide services under this waiver;
 - Assurance that the standards of any State licensure or certification requirements specified in **Appendix C** are met for services or for individuals furnishing services that are provided under the waiver. The State assures that these requirements are met on the date that the services are furnished; and,
 - Assurance that all facilities subject to §1616(e) of the Act where home and community-based waiver services are provided comply with the applicable State standards for board and care facilities as specified in **Appendix C**.
- B. Financial Accountability.** The State assures financial accountability for funds expended for home and community-based services and maintains and makes available to the Department of Health and Human Services (including the Office of the Inspector General), the Comptroller General, or other designees, appropriate financial records documenting the cost of services provided under the waiver. Methods of financial accountability are specified in **Appendix I**.
- C. Evaluation of Need:** The State assures that it provides for an initial evaluation (and periodic reevaluations, at least annually) of the need for a level of care specified for this waiver, when there is a reasonable indication that an individual might need such services in the near future (one month or less) but for the receipt of home and community-based services under this waiver. The procedures for evaluation and reevaluation of level of care are specified in **Appendix B**.

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- D. Choice of Alternatives:** The State assures that when an individual is determined to be likely to require the level of care specified for this waiver and is in a target group specified in **Appendix B**, the individual (or, legal representative, if applicable) is:
1. Informed of any feasible alternatives under the waiver; and,
 2. Given the choice of either institutional or home and community-based waiver services.
- Appendix B** specifies the procedures that the State employs to ensure that individuals are informed of feasible alternatives under the waiver and given the choice of institutional or home and community-based waiver services.
- E. Average Per Capita Expenditures:** The State assures that, for any year that the waiver is in effect, the average per capita expenditures under the waiver will not exceed 100 percent of the average per capita expenditures that would have been made under the Medicaid State plan for the level(s) of care specified for this waiver had the waiver not been granted. Cost-neutrality is demonstrated in **Appendix J**.
- F. Actual Total Expenditures:** The State assures that the actual total expenditures for home and community-based waiver and other Medicaid services and its claim for FFP in expenditures for the services provided to individuals under the waiver will not, in any year of the waiver period, exceed 100 percent of the amount that would be incurred in the absence of the waiver by the State's Medicaid program for these individuals in the institutional setting(s) specified for this waiver.
- G. Institutionalization Absent Waiver:** The State assures that, absent the waiver, individuals served in the waiver would receive the appropriate type of Medicaid-funded institutional care for the level of care specified for this waiver.
- H. Reporting:** The State assures that annually it will provide CMS with information concerning the impact of the waiver on the type, amount and cost of services provided under the Medicaid State plan and on the health and welfare of waiver participants. This information will be consistent with a data collection plan designed by CMS.
- I. Habilitation Services.** The State assures that prevocational, educational, or supported employment services, or a combination of these services, if provided as habilitation services under the waiver are: (1) not otherwise available to the individual through a local educational agency under the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) or the Rehabilitation Act of 1973; and, (2) furnished as part of expanded habilitation services.
- J. Services for Individuals with Chronic Mental Illness.** The State assures that federal financial participation (FFP) will not be claimed in expenditures for waiver services including, but not limited to, day treatment or partial hospitalization, psychosocial rehabilitation services, and clinic services provided as home and community-based services to individuals with chronic mental illnesses if these individuals, in the absence of a waiver, would be placed in an IMD and are: (1) age 22 to 64; (2) age 65 and older and the State has not included the optional Medicaid benefit cited in 42 CFR §440.140; or (3) under age 21 when the State has not included the optional Medicaid benefit cited in 42 CFR §440.160.

6. Additional Requirements

Note: Item 6-I must be completed.

- A. Service Plan.** In accordance with 42 CFR §441.301(b)(1)(i), a participant-centered service plan (of care) is developed for each participant employing the procedures specified in **Appendix D**. All waiver services are furnished pursuant to the service plan. The service plan describes: (a) the waiver services that are furnished to the participant, their projected amount, frequency and duration and the type of provider that furnishes each service and (b) the other services (regardless of funding source, including State plan services) and informal supports that complement waiver services in meeting the needs of the participant. The service plan is subject to the approval of the Medicaid agency. Federal financial

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participation (FFP) is not claimed for waiver services furnished prior to the development of the service plan or for services that are not included in the service plan.

- B. Inpatients.** In accordance with 42 CFR §441.301(b)(1)(ii), waiver services are not furnished to individuals who are in-patients of a hospital, nursing facility or ICF/MR.
- C. Room and Board.** In accordance with 42 CFR §441.310(a)(2), FFP is not claimed for the cost of room and board except when: (a) provided as part of respite services in a facility approved by the State that is not a private residence or (b) claimed as a portion of the rent and food that may be reasonably attributed to an unrelated caregiver who resides in the same household as the participant, as provided in **Appendix I**.
- D. Access to Services.** The State does not limit or restrict participant access to waiver services except as provided in **Appendix C**.
- E. Free Choice of Provider.** In accordance with 42 CFR §431.51, a participant may select any willing and qualified provider to furnish waiver services included in the service plan unless the State has received approval to limit the number of providers under the provisions of §1915(b) or another provision of the Act.
- F. FFP Limitation.** In accordance with 42 CFR §433 Subpart D, FFP is not claimed for services when another third-party (e.g., another third party health insurer or other federal or state program) is legally liable and responsible for the provision and payment of the service. FFP also may not be claimed for services that are available without charge, or as free care to the community. Services will not be considered to be without charge, or free care, when (1) the provider establishes a fee schedule for each service available and (2) collects insurance information from all those served (Medicaid, and non-Medicaid), and bills other legally liable third party insurers. Alternatively, if a provider certifies that a particular legally liable third party insurer does not pay for the service(s), the provider may not generate further bills for that insurer for that annual period.
- G. Fair Hearing:** The State provides the opportunity to request a Fair Hearing under 42 CFR §431 Subpart E, to individuals: (a) who are not given the choice of home and community-based waiver services as an alternative to institutional level of care specified for this waiver; (b) who are denied the service(s) of their choice or the provider(s) of their choice; or (c) whose services are denied, suspended, reduced or terminated. **Appendix F** specifies the State's procedures to provide individuals the opportunity to request a Fair Hearing, including providing notice of action as required in 42 CFR §431.210.
- H. Quality Management.** The State operates a formal, comprehensive system to ensure that the waiver meets the assurances and other requirements contained in this application. Through an ongoing process of discovery, remediation and improvement, the State assures the health and welfare of participants by monitoring: (a) level of care determinations; (b) individual plans and services delivery; (c) provider qualifications; (d) participant health and welfare; (e) financial oversight and (f) administrative oversight of the waiver. The State further assures that all problems identified through its discovery processes are addressed in an appropriate and timely manner, consistent with the severity and nature of the problem. During the period that the waiver is in effect, the State will implement the Quality Management Strategy specified in **Appendix H**.
- I. Public Input.** Describe how the State secures public input into the development of the waiver:

Information for the development of the waiver was obtained from a work group consisting of: Consumers, OAA service providers, County Social Service Boards, AARP, Protection & Advocacy, Independent Living Centers, Long Term Care Association, ND Disabilities Consortium, Waiver service providers, and Department of Human Services staff. Additional information was obtained through statewide Department of Human Services stakeholder meetings and Aging Services/HCBS State input hearings.

The draft Waiver was forwarded to tribal entities and interested parties prior to the submission of the renewal request to CMS.

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- J. Notice to Tribal Governments.** The State assures that it has notified in writing all federally-recognized Tribal Governments that maintain a primary office and/or majority population within the State of the State's intent to submit a Medicaid waiver request or renewal request to CMS at least 60 days before the anticipated submission date as provided by Presidential Executive Order 13175 of November 6, 2000. Evidence of the applicable notice is available through the Medicaid Agency.
- K. Limited English Proficient Persons.** The State assures that it provides meaningful access to waiver services by Limited English Proficient persons in accordance with: (a) Presidential Executive Order 13166 of August 11, 2000 (65 FR 50121) and (b) Department of Health and Human Services "Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons" (68 FR 47311 - August 8, 2003). **Appendix B** describes how the State assures meaningful access to waiver services by Limited English Proficient persons.

7. Contact Person(s)

- A.** The Medicaid agency representative with whom CMS should communicate regarding the waiver is:

First Name:	Theresa
Last Name	Frohlich
Title:	HCBS Program Administrator
Agency:	ND Department of Human Services
Address 1:	Medical Services Division/HCBS
Address 2:	600 E Blvd, Dept 325
City	Bismarck
State	ND
Zip Code	58505-0250
Telephone:	701-328-4630
E-mail	sofrot@nd.gov
Fax Number	701-328-4061

- B.** If applicable, the State operating agency representative with whom CMS should communicate regarding the waiver is:

First Name:	
Last Name	
Title:	
Agency:	
Address 1:	
Address 2	
City	
State	
Zip Code	
Telephone:	
E-mail	

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8. Authorizing Signature

This document, together with Appendices A through J, constitutes the State's request for a waiver under §1915(c) of the Social Security Act. The State assures that all materials referenced in this waiver application (including standards, licensure and certification requirements) are ***readily*** available in print or electronic form upon request to CMS through the Medicaid agency or, if applicable, from the operating agency specified in Appendix A. Any proposed changes to the waiver will be submitted by the Medicaid agency to CMS in the form of waiver amendments.

Upon approval by CMS, the waiver application serves as the State's authority to provide home and community-based waiver services to the specified target groups. The State attests that it will abide by all provisions of the approved waiver and will continuously operate the waiver in accordance with the assurances specified in Section 5 and the additional requirements specified in Section 6 of the request.

Signature: _____

Date: December 31, 2006

State Medicaid Director or Designee

First Name:	Maggie
Last Name	Anderson
Title:	Director, Medical Services Division
Agency:	ND Department of Human Services
Address 1:	Medical Services Division
Address 2:	600 E Blvd, Dept 325
City	Bismarck
State	ND
Zip Code	58505-0250
Telephone:	701-328-2321
E-mail	soandm@nd.gov
Fax Number	701-328-1544

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Attachment #1: Transition Plan

Specify the transition plan for the waiver:

N/A, renewal request

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Appendix A: Waiver Administration and Operation

- 1. State Line of Authority for Waiver Operation.** Specify the state line of authority for the operation of the waiver (*select one*):

<input checked="" type="radio"/>	The waiver is operated by the State Medicaid agency. Specify the Medicaid agency division/unit that has line authority for the operation of the waiver program (<i>select one; do not complete Item A-2</i>):	
<input checked="" type="radio"/>	The Medical Assistance Unit (<i>name of unit</i>):	Long Term Care Continuum Unit, Medical Services Division
<input type="radio"/>	Another division/unit within the State Medicaid agency that is separate from the Medical Assistance Unit (name of division/unit)	
<input type="radio"/>	The waiver is operated by a separate agency of the State that is not a division/unit of the Medicaid agency. In accordance with 42 CFR §431.10, the Medicaid agency exercises administrative discretion in the administration and supervision of the waiver and issues policies, rules and regulations related to the waiver. The interagency agreement or memorandum of understanding that sets forth the authority and arrangements for this policy is available through the Medicaid agency to CMS upon request. <i>Complete item A-2.</i>	

- 2. Medicaid Agency Oversight of Operating Agency Performance.** When the waiver is not operated by the Medicaid agency, specify the methods that the Medicaid agency uses to ensure that the operating agency performs its assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify the frequency of Medicaid agency assessment of operating agency performance:

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- 3. Use of Contracted Entities.** Specify whether contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the waiver operating agency (if applicable) (*select one*):

<input checked="" type="radio"/>	<p>Yes. Contracted entities perform waiver operational and administrative functions on behalf of the Medicaid agency and/or the operating agency (if applicable). Specify the types of contracted entities and briefly describe the functions that they perform. <i>Complete Items A-5 and A-6.</i></p> <p>The Department maintains a contract with Dual Diagnosis Management to complete skilled nursing facility level of care determinations that ensures eligibility criteria are met for participation in the waiver.</p>
<input type="radio"/>	No. Contracted entities do not perform waiver operational and administrative functions on

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behalf of the Medicaid agency and/or the operating agency (if applicable).

4. **Role of Local/Regional Non-State Entities.** Indicate whether local or regional non-state entities perform waiver operational and administrative functions and, if so, specify the type of entity (*check each that applies*):

<input checked="" type="checkbox"/>	Local/Regional non-state public agencies conduct waiver operational and administrative functions at the local or regional level. There is an interagency agreement or memorandum of understanding between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state agency that sets forth the responsibilities and performance requirements of the local/regional agency. The interagency agreement or memorandum of understanding is available through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these agencies and complete items A-5 and A-6:</i>
<input type="checkbox"/>	Local/Regional non-governmental non-state entities conduct waiver operational and administrative functions at the local or regional level. There is a contract between the Medicaid agency and/or the operating agency (when authorized by the Medicaid agency) and each local/regional non-state entity that sets forth the responsibilities and performance requirements of the local/regional entity. The contract(s) under which private entities conduct waiver operational functions are available to CMS upon request through the Medicaid agency or the operating agency (if applicable). <i>Specify the nature of these entities and complete items A-5 and A-6:</i>
<input type="checkbox"/>	Not applicable – Local/regional non-state agencies do not perform waiver operational and administrative functions

5. **Responsibility for Assessment of Performance of Contracted and/or Local/Regional Non-State Entities.** Specify the state agency or agencies responsible for assessing the performance of contracted and/or local/regional non-state entities in conducting waiver operational and administrative functions:

Medical Services Division, North Dakota Department of Human Services

6. **Assessment Methods and Frequency.** Describe the methods that are used to assess the performance of contracted and/or local/regional non-state entities to ensure that they perform assigned waiver operational and administrative functions in accordance with waiver requirements. Also specify how frequently the performance of contracted and/or local/regional non-state entities is assessed:

Counties are reviewed every year, either on-site or desk audit.

Dual Diagnosis Management is monitored by daily reporting via web application, monthly reports from DDM to the Department, input from counties regarding service performance, weekly telephone contact with DDM regarding contract components and input of screening into MMIS assuring timely completion of reviews.

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Appendix A: Waiver Administration and Operation

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- 7. Distribution of Waiver Operational and Administrative Functions.** In the following table, specify the entity or entities that have responsibility for conducting each of the waiver operational and administrative functions listed (*check each that applies*):

In accordance with 42 CFR §431.10, when the Medicaid agency does not directly conduct a function, it supervises the performance of the function and establishes and/or approves policies that affect the function.

Function	Medicaid Agency	Other State Operating Agency	Contracted Entity	Local Non-State Entity
Disseminate information concerning the waiver to potential enrollees	X	<input type="checkbox"/>	<input type="checkbox"/>	X
Assist individuals in waiver enrollment	X	<input type="checkbox"/>	<input type="checkbox"/>	X
Manage waiver enrollment against approved limits	X	<input type="checkbox"/>	<input type="checkbox"/>	X
Monitor waiver expenditures against approved levels	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct level of care evaluation activities	X	<input type="checkbox"/>	X	<input type="checkbox"/>
Review participant service plans to ensure that waiver requirements are met	X	<input type="checkbox"/>	<input type="checkbox"/>	X
Perform prior authorization of waiver services	X	<input type="checkbox"/>	<input type="checkbox"/>	X
Conduct utilization management functions	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recruit providers	X	<input type="checkbox"/>	<input type="checkbox"/>	X
Execute the Medicaid provider agreement	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Determine waiver payment amounts or rates	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Conduct training and technical assistance concerning waiver requirements	X	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Appendix B: Participant Access and Eligibility

Appendix B-1: Specification of the Waiver Target Group(s)

- a. Target Group(s).** Under the waiver of Section 1902(a)(10)(B) of the Act, the State limits waiver services to a group or subgroups of individuals. *In accordance with 42 CFR §441.301(b)(6), select one waiver target group, check each subgroup in the selected target group that may receive services under the waiver, and specify the minimum and maximum (if any) age of individuals served in each subgroup:*

INCLUDED	TARGET GROUP/SUBGROUP	MINIMUM AGE	MAXIMUM AGE	
			MAXIMUM AGE LIMIT: THROUGH AGE –	NO MAXIMUM AGE LIMIT
<input type="radio"/>	Aged or Disabled, or Both			
<input checked="" type="checkbox"/>	Aged (age 65 and older)			<input checked="" type="checkbox"/>
<input checked="" type="checkbox"/>	Disabled (Physical) (under age 65)			
<input checked="" type="checkbox"/>	Disabled (Other) (under age 65)			
	Specific Aged/Disabled Subgroup			
<input checked="" type="checkbox"/>	Brain Injury	18		<input checked="" type="checkbox"/>
<input type="checkbox"/>	HIV/AIDS			<input type="checkbox"/>
<input type="checkbox"/>	Medically Fragile			<input type="checkbox"/>
<input checked="" type="checkbox"/>	Technology Dependent	18		<input checked="" type="checkbox"/>
<input type="radio"/>	Mental Retardation or Developmental Disability, or Both			
<input type="checkbox"/>	Autism			<input type="checkbox"/>
<input type="checkbox"/>	Developmental Disability			<input type="checkbox"/>
<input type="checkbox"/>	Mental Retardation			<input type="checkbox"/>
<input type="radio"/>	Mental Illness			
<input type="checkbox"/>	Mental Illness (age 18 and older)			<input type="checkbox"/>
<input type="checkbox"/>	Serious Emotional Disturbance (under age 18)			

- b. Additional Criteria.** The State further specifies its target group(s) as follows:

Brain Injury: Individuals diagnosed with a brain injury (traumatic or acquired – Waiver services are limited to individuals with the following disease(s) or conditions(s): a diagnosis, which is not degenerative or congenital, of traumatic brain injury or acquired brain injury (e.g. anoxia, infections, CVA, aneurysms, tumors which are not expected to result in death, toxic chemical reactions) resulting in significant emotional, behavioral, or cognitive impairments. are restricted to those individuals who have been diagnosed by a neuropsychologist as having a brain injury and supported by a neuropsychological evaluation. These individuals cannot be enrolled in a IEP; disabled by SSA criteria or determined disabled by the State Team; and must be capable of directing own care or have a responsible party act in the consumer's behalf.

Technology Dependent - For individuals requiring technology dependency, in order to be eligible for this Waiver, the individual must be ventilator dependent for a minimum of 20 hours per day, must be medically stable as determined by a physician on an annual basis or as requested by the Department; have an informal caregiver support system for contingency planning; determined competent as documented by the primary care physician on an annual basis or as requested by the Department; to actively participate in the development and monitoring of the plan of care.

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- c. Transition of Individuals Affected by Maximum Age Limitation.** When there is a maximum age limit that applies to individuals who may be served in the waiver, describe the transition planning procedures that are undertaken on behalf of participants affected by the age limit (*select one*):

X	Not applicable – There is no maximum age limit
C	The following transition planning procedures are employed for participants who will reach the waiver's maximum age limit (<i>specify</i>): <div style="background-color: #cccccc; height: 40px; margin-top: 5px;"></div>

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Appendix B-2: Individual Cost Limit

- a. **Individual Cost Limit.** The following individual cost limit applies when determining whether to deny home and community-based services or entrance to the waiver to an otherwise eligible individual (*select one*):

<input type="radio"/>	No Cost Limit. The State does not apply an individual cost limit. <i>Do not complete Item B-2-b or Item B-2-c.</i>		
<input type="radio"/>	Cost Limit in Excess of Institutional Costs. The State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed the cost of a level of care specified for the waiver up to an amount specified by the State. <i>Complete Items B-2-b and B-2-c.</i> The limit specified by the State is (<i>select one</i>):		
<input type="radio"/>		%, a level higher than 100% of the institutional average	
<input type="radio"/>	Other (<i>specify</i>):		
<input type="radio"/>	Institutional Cost Limit. Pursuant to 42 CFR 441.301(a)(3), the State refuses entrance to the waiver to any otherwise eligible individual when the State reasonably expects that the cost of the home and community-based services furnished to that individual would exceed 100% of the cost of the level of care specified for the waiver. <i>Complete Items B-2-b and B-2-c.</i>		
<input type="radio"/>	Cost Limit Lower Than Institutional Costs. The State refuses entrance to the waiver to any otherwise qualified individual when the State reasonably expects that the cost of home and community-based services furnished to that individual would exceed the following amount specified by the State that is less than the cost of a level of care specified for the waiver. <i>Specify the basis of the limit, including evidence that the limit is sufficient to assure the health and welfare of waiver participants. Complete Items B-2-b and B-2-c.</i>		
	The cost limit specified by the State is (<i>select one</i>):		
<input type="radio"/>	The following dollar amount: \$		
	The dollar amount (<i>select one</i>):		
<input type="radio"/>	Is adjusted each year that the waiver is in effect by applying the following formula:		
<input type="radio"/>	May be adjusted during the period the waiver is in effect. The State will submit a waiver amendment to CMS to adjust the dollar amount.		
<input type="radio"/>	The following percentage that is less than 100% of the institutional average:		%
X	Other – <i>Specify</i> :		

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	<p>For consumers receiving Attendant care Service and Nurse Management Service, cost is limited to the highest rate allowed to a nursing facility within the rate setting structure of the Department of Human Services.</p> <p>For consumers receiving TBI Residential Care, cost is limited to the rate allowed for the specialized nursing facility that serves brain injured individuals.</p> <p>All other consumers receiving waiver services are limited to the average rate allowed for nursing facilities within the rate setting structure of the Department of Human Services.</p>
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- b. Method of Implementation of the Individual Cost Limit.** When an individual cost limit is specified in Item B-2-a, specify the procedures that are followed to determine in advance of waiver entrance that the individual's health and welfare can be assured within the cost limit:

A comprehensive assessment will identify the formal and informal service needs of the individual and provider availability. If the plan of care could not assure the health, welfare, and safety of the individual, services would be denied. The individual would receive appropriate notification of appeal rights.

- c. Participant Safeguards.** When the State specifies an individual cost limit in Item B-2-a and there is a change in the participant's condition or circumstances post-entrance to the waiver that requires the provision of services in an amount that exceeds the cost limit in order to assure the participant's health and welfare, the State has established the following safeguards to avoid an adverse impact on the participant (*check each that applies*):

<input type="checkbox"/>	The participant is referred to another waiver that can accommodate the individual's needs.
<input type="checkbox"/>	Additional services in excess of the individual cost limit may be authorized. Specify the procedures for authorizing additional services, including the amount that may be authorized:
X	Other safeguard(s) (<i>specify</i>):
	Case Management services will assist the individual to identify other community resources or options. If the comprehensive assessment identifies that the formal and informal service needs of the individual and provider availability are not adequate to assure the health, welfare, and safety of the individual. Services would be terminated. The individual would receive appropriate notification of appeal rights.

Appendix B-3: Number of Individuals Served

- a. **Unduplicated Number of Participants.** The following table specifies the maximum number of unduplicated participants who are served in each year that the waiver is in effect. The State will submit a waiver amendment to CMS to modify the number of participants specified for any year(s), including when a modification is necessary due to legislative appropriation or another reason. The number of unduplicated participants specified in this table is basis for the cost-neutrality calculations in Appendix J:

Table: B-3-a	
Waiver Year	Unduplicated Number of Participants
Year 1	400
Year 2	427
Year 3	454
Year 4 (renewal only)	481
Year 5 (renewal only)	508

- b. **Limitation on the Number of Participants Served at Any Point in Time.** Consistent with the unduplicated number of participants specified in Item B-3-a, the State may limit to a lesser number the number of participants who will be served at any point in time during a waiver year. Indicate whether the State limits the number of participants in this way: (*select one*):

<input checked="" type="radio"/>	The State does not limit the number of participants that it serves at any point in time during a waiver year.
<input type="radio"/>	The State limits the number of participants that it serves at any point in time during a waiver year. The limit that applies to each year of the waiver period is specified in the following table:

Table B-3-b	
Waiver Year	Maximum Number of Participants Served At Any Point During the Year
Year 1	
Year 2	
Year 3	
Year 4 (renewal only)	
Year 5 (renewal only)	

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- c. Reserved Waiver Capacity.** The State may reserve a portion of the participant capacity of the waiver for specified purposes (e.g., provide for the community transition of institutionalized persons or furnish waiver services to individuals experiencing a crisis) subject to CMS review and approval. The State (*select one*):

<input type="radio"/>	Not applicable. The state does not reserve capacity.		
<input checked="" type="radio"/>	The State reserves capacity for the following purpose(s). For each purpose, describe how the amount of reserved capacity was determined:		
	We request limited capacity for Attendant Care Services for individuals dependent upon ventilators to no more than three participants at any time during each year of the waiver. Due to the high care and cost requirements of these persons, new entrants requiring technology dependent services must be restricted to State fund match financial limits.		
	The capacity that the State reserves in each waiver year is specified in the following table:		
	Table B-3-c		
		Purpose:	Purpose:
		To restrict capacity to no more than 3 individuals at any one time per Waiver year.	
	Waiver Year	Capacity Reserved	Capacity Reserved
	Year 1	3	
	Year 2	3	
	Year 3	3	
	Year 4 (renewal only)	3	
	Year 5 (renewal only)	3	

- d. Scheduled Phase-In or Phase-Out.** Within a waiver year, the State may make the number of participants who are served subject to a phase-in or phase-out schedule (*select one*):

<input checked="" type="radio"/>	The waiver is not subject to a phase-in or a phase-out schedule.
<input type="radio"/>	The waiver is subject to a phase-in or phase-out schedule that is included in Attachment #1 to Appendix B-3. This schedule constitutes an <i>intra-year</i> limitation on the number of participants who are served in the waiver.

- e. Allocation of Waiver Capacity.** *Select one:*

<input checked="" type="radio"/>	Waiver capacity is allocated/managed on a statewide basis.
<input type="radio"/>	Waiver capacity is allocated to local/regional non-state entities. Specify: (a) the entities to which waiver capacity is allocated; (b) the methodology that is used to allocate capacity and how often the methodology is reevaluated; and, (c) policies for the reallocation of unused capacity among local/regional non-state entities:

f. Selection of Entrants to the Waiver. Specify the policies that apply to the selection of individuals for entrance to the waiver:

Case Managers assess the need of services through a comprehensive assessment. Once eligibility is determined, the applicant must choose an enrolled service provider(s). Pre-authorization of service would be implemented. New entrants into the Waiver occur once all of the eligibility criteria have been met and the service provider is authorized. Case Managers authorize Waiver services without prior approval from the Department. The Department currently does not have a waiting list for Waivered services for the aged and disabled.

In the event projections would reflect a potential waiting list, either due to restricted capacity levels or appropriation shortfalls, the Department will require the Case Managers to seek prior approval for a Waiver slot. The Department would approve services on a first come/first serve basis once a pre-approval package, reflecting eligibility criteria has been met, is forwarded to the State.

For Attendant Care service, the Department will review eligibility, evaluate the plan of care, evaluate preliminary cost proposals, and prior approve applicants.

For Transitional Living and Residential Care Services, the Department will review eligibility, evaluate the plan of care, and prior approve applicants.

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Waiver Phase-In/Phase Out Schedule

- | | |
|-----------------------|------------|
| <input type="radio"/> | Phased-in |
| <input type="radio"/> | Phased-out |

- | Year One | Year Two | Year Three | Year Four | Your Five |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- | | Month | Waiver Year |
|-----------------------------------|-------|-------------|
| Waiver Year: First Calendar Month | | |
| Phase-in/Phase out begins | | |
| Phase-in/Phase out ends | | |

- [illegible]

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Appendix B-4: Medicaid Eligibility Groups Served in the Waiver

a. **State Classification.** The State is a (*select one*):

<input type="radio"/>	§1634 State
<input type="radio"/>	SSI Criteria State
<input checked="" type="radio"/>	209(b) State

b. **Medicaid Eligibility Groups Served in the Waiver.** Individuals who receive services under this waiver are eligible under the following eligibility groups contained in the State plan. The State applies all applicable federal financial participation limits under the plan. *Check all that apply:*

Eligibility Groups Served in the Waiver (excluding the special home and community-based waiver group under 42 CFR §435.217)	
<input type="checkbox"/>	Low income families with children as provided in §1931 of the Act
<input type="checkbox"/>	SSI recipients
<input checked="" type="checkbox"/>	Aged, blind or disabled in 209(b) states who are eligible under 42 CFR §435.121
<input type="checkbox"/>	Optional State supplement recipients
<input type="checkbox"/>	Optional categorically needy aged and/or disabled individuals who have income at: (<i>select one</i>)
<input type="radio"/>	100% of the Federal poverty level (FPL)
<input type="radio"/>	% of FPL, which is lower than 100% of FPL
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (BBA working disabled group as provided in §1902(a)(10)(A)(ii)(XIII) of the Act)
<input type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Basic Coverage Group as provided in §1902(a)(10)(A)(ii)(XV) of the Act)
<input checked="" type="checkbox"/>	Working individuals with disabilities who buy into Medicaid (TWWIIA Medical Improvement Coverage Group as provided in §1902(a)(10)(A)(ii)(XVI) of the Act)
<input type="checkbox"/>	Disabled individuals age 18 or younger who would require an institutional level of care (TEFRA 134 eligibility group as provided in §1902(e)(3) of the Act)
<input checked="" type="checkbox"/>	Medically needy
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :
Special home and community-based waiver group under 42 CFR §435.217) Note: When the special home and community-based waiver group under 42 CFR §435.217 is included, Appendix B-5 must be completed	
<input checked="" type="radio"/>	No. The State does not furnish waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. Appendix B-5 is not submitted.
<input type="radio"/>	Yes. The State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217. <i>Select one and complete Appendix B-5.</i>
<input type="radio"/>	All individuals in the special home and community-based waiver group under 42 CFR §435.217

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<input type="radio"/>	Only the following groups of individuals in the special home and community-based waiver group under 42 CFR §435.217 (<i>check each that applies</i>):		
<input type="checkbox"/>	A special income level equal to (select one):		
<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)		
<input type="radio"/>	%	of FBR, which is lower than 300% (42 CFR §435.236)	
<input type="radio"/>	\$	which is lower than 300%	
<input type="checkbox"/>	Aged, blind and disabled individuals who meet requirements that are more restrictive than the SSI program (42 CFR §435.121)		
<input type="checkbox"/>	Medically needy without spenddown in States which also provide Medicaid to recipients of SSI (42 CFR §435.320, §435.322 and §435.324)		
<input type="checkbox"/>	Medically needy without spend down in 209(b) States (42 CFR §435.330)		
<input type="checkbox"/>	Aged and disabled individuals who have income at: (<i>select one</i>)		
<input type="radio"/>	100% of FPL		
<input type="radio"/>	%	of FPL, which is lower than 100%	
<input type="checkbox"/>	Other specified groups (include only the statutory/regulatory reference to reflect the additional groups in the State plan that may receive services under this waiver) <i>specify</i> :		

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Appendix B-5: Post-Eligibility Treatment of Income

In accordance with 42 CFR §441.303(e), Appendix B-5 must be completed when the State furnishes waiver services to individuals in the special home and community-based waiver group under 42 CFR §435.217, as indicated in Appendix B-4. Post-eligibility applies only to the 42 CFR §435.217 group. A State that uses spousal impoverishment rules under §1924 of the Act to determine the eligibility of individuals with a community spouse may elect to use spousal post-eligibility rules under §1924 of the Act to protect a personal needs allowance for a participant with a community spouse.

- a. **Use of Spousal Impoverishment Rules.** Indicate whether spousal impoverishment rules are used to determine eligibility for the special home and community-based waiver group under 42 CFR §435.217 (*select one*):

- **Does not apply. The waiver does not serve the 435.217 Group.**

<input type="radio"/>	Spousal impoverishment rules under §1924 of the Act are used to determine the eligibility of individuals with a community spouse for the special home and community-based waiver group. In the case of a participant with a community spouse, the State elects to (<i>select one</i>):
<input type="radio"/>	Use <i>spousal</i> post-eligibility rules under §1924 of the Act. <i>Complete Items B-5-b-2 (SSI State) or B-5-c-2 (209b State) and Item B-5-d.</i>
<input type="radio"/>	Use <i>regular</i> post-eligibility rules under 42 CFR §435.726 (SSI State) (<i>Complete Item B-5-b-1</i>) or under §435.735 (209b State) (<i>Complete Item B-5-c-1</i>). <i>Do not complete Item B-5-d.</i>
<input type="radio"/>	Spousal impoverishment rules under §1924 of the Act are not used to determine eligibility of individuals with a community spouse for the special home and community-based waiver group. The State uses regular post-eligibility rules for individuals with a community spouse. <i>Complete Item B-5-c-1 (SSI State) or Item B-5-d-1 (209b State). Do not complete Item B-5-d.</i>

NOTE: Items B-5-b-1 and B-5-c-1 are for use by states that do not use spousal eligibility rules or use spousal impoverishment eligibility rules but elect to use regular post-eligibility rules.

- b-1. **Regular Post-Eligibility Treatment of Income: SSI State.** The State uses the post-eligibility rules at 42 CFR §435.726. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant (<i>select one</i>):			
<input type="radio"/>	The following standard included under the State plan (<i>select one</i>):		
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons (<i>select one</i>):		
<input type="radio"/>	C	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	C	%	of the FBR, which is less than 300%
<input type="radio"/>	C	\$	which is less than 300%.
<input type="radio"/>		%	of the Federal poverty level
<input type="radio"/>	Other (specify):		
<input type="radio"/>			

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<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable (see instructions)		
iii. Allowance for the family (select one):			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Other (specify):		
<input type="radio"/>	Not applicable (see instructions)		
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 §CFR 435.726:			
a. Health insurance premiums, deductibles and co-insurance charges			
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>			
<input type="radio"/>	The State does not establish reasonable limits.		
<input type="radio"/>	The State establishes the following reasonable limits (specify):		

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- c-1. Regular Post-Eligibility: 209(b) State.** The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant <i>(select one)</i> :			
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>		
	<input type="radio"/>	The following standard under 42 CFR §435.121:	
	<input type="radio"/>	Optional State supplement standard	
	<input type="radio"/>	Medically needy income standard	
	<input type="radio"/>	The special income level for institutionalized persons <i>(select one)</i>	
	<input type="radio"/>	300% of the SSI Federal Benefit Rate (FBR)	
	<input type="radio"/>	%	of the FBR, which is less than 300%
	<input type="radio"/>	\$	which is less than 300% of the FBR
	<input type="radio"/>	%	of the Federal poverty level
	<input type="radio"/>	Other (specify):	
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only <i>(select one)</i> :			
<input type="radio"/>	The following standard under 42 CFR §435.121		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable <i>(see instructions)</i>		
iii. Allowance for the family <i>(select one)</i>			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		

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<input type="radio"/>	The following dollar amount: \$ <input type="text"/> The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <input type="text"/>
<input type="radio"/>	Other (specify): <input type="text"/>
<input type="radio"/>	Not applicable (see instructions)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.735:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits (<i>specify</i>): <input type="text"/>

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NOTE: Items B-5-c-2 and B-5-d-2 are for use by states that use spousal impoverishment eligibility rules and elect to apply the spousal post eligibility rules.

b-2. Regular Post-Eligibility Treatment of Income: SSI State. The State uses the post-eligibility rules at 42 CFR §435.726 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following allowances and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant <i>(select one):</i>			
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>		
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons <i>(select one):</i>		
<input type="radio"/>	C	300% of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	C	%	of the FBR, which is less than 300%
<input type="radio"/>	C	\$	which is less than 300%.
<input type="radio"/>		%	of the Federal poverty level
<input type="radio"/>	Other (specify):		
<input type="radio"/>			
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
<input type="radio"/>			
ii. Allowance for the spouse only <i>(select one):</i>			
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
<input type="radio"/>			
<input type="radio"/>	Specify the amount of the allowance:		
<input type="radio"/>	SSI standard		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>			
<input type="radio"/>	Not applicable		

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iii. Allowance for the family <i>(select one):</i>	
<input type="radio"/>	AFDC need standard
<input type="radio"/>	Medically needy income standard
<input type="radio"/>	The following dollar amount: \$ The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="radio"/>	Other (specify): <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>
<input type="radio"/>	Not applicable (see instructions)
iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR §435.726:	
a. Health insurance premiums, deductibles and co-insurance charges	
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>	
<input type="radio"/>	The State does not establish reasonable limits.
<input type="radio"/>	The State establishes the following reasonable limits <i>(specify)</i> : <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>

c-2. Regular Post-Eligibility: 209(b) State. The State uses more restrictive eligibility requirements than SSI and uses the post-eligibility rules at 42 CFR §435.735 for individuals who do not have a spouse or have a spouse who is not a community spouse as specified in §1924 of the Act. Payment for home and community-based waiver services is reduced by the amount remaining after deducting the following amounts and expenses from the waiver participant's income:

i. Allowance for the needs of the waiver participant <i>(select one):</i>			
<input type="radio"/>	The following standard included under the State plan <i>(select one)</i>		
<input type="radio"/>	The following standard under 42 CFR §435.121: <div style="border: 1px solid black; height: 20px; width: 100%; margin-top: 5px;"></div>		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The special income level for institutionalized persons <i>(select one)</i>		
<input type="radio"/>	300%	of the SSI Federal Benefit Rate (FBR)	
<input type="radio"/>	%	of the FBR, which is less than 300%	
<input type="radio"/>	\$	which is less than 300% of the FBR	
<input type="radio"/>	%	of the Federal poverty level	

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<input type="radio"/>	Other (specify):		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The following formula is used to determine the needs allowance:		
ii. Allowance for the spouse only (select one):			
<input type="radio"/>	The state provides an allowance for a spouse who does not meet the definition of a community spouse in §1924 of the Act. Describe the circumstances under which this allowance is provided:		
	Specify the amount of the allowance:		
<input type="radio"/>	The following standard under 42 CFR §435.121:		
<input type="radio"/>	Optional State supplement standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Not applicable		
iii. Allowance for the family (select one)			
<input type="radio"/>	AFDC need standard		
<input type="radio"/>	Medically needy income standard		
<input type="radio"/>	The following dollar amount:	\$	The amount specified cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 42 CFR §435.811 for a family of the same size. If this amount changes, this item will be revised.
<input type="radio"/>	The amount is determined using the following formula:		
<input type="radio"/>	Other (specify):		
<input type="radio"/>	Not applicable (see instructions)		

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iv. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified in 42 CFR 435.735:

- a. Health insurance premiums, deductibles and co-insurance charges
- b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. *Select one:*

☐ The State does not establish reasonable limits.

☐ The State establishes the following reasonable limits (*specify*):

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d. Post-Eligibility Treatment of Income Using Spousal Impoverishment Rules

The State uses the post-eligibility rules of §1924(d) of the Act (spousal impoverishment protection) to determine the contribution of a participant with a community spouse toward the cost of home and community-based care if it determines the individual's eligibility under §1924 of the Act. There is deducted from the participant's monthly income a personal needs allowance (as specified below), a community spouse's allowance, a family allowance, and an amount for incurred expenses for medical or remedial care.

i. Allowance for the personal needs of the waiver participant <i>(select one):</i>		
<input type="radio"/>	SSI Standard	
<input type="radio"/>	Optional State Supplement standard	
<input type="radio"/>	Medically Needy Income Standard	
<input type="radio"/>	The special income level for institutionalized persons	
<input type="radio"/>	%	of the Federal Poverty Level
<input type="radio"/>	The following dollar amount: \$	If this amount changes, this item will be revised
<input type="radio"/>	The following formula is used to determine the needs allowance:	
<input type="radio"/>	Other <i>(specify)</i> :	
ii. If the allowance for the personal needs of a waiver participant with a community spouse is different from the amount used for the individual's maintenance allowance under 42 CFR §435.726 or 42 CFR §435.735, explain why this amount is reasonable to meet the individual's maintenance needs in the community. <i>Select one:</i>		
<input type="radio"/>	Allowance is the same	
<input type="radio"/>	Allowance is different. Explanation of difference:	
iii. Amounts for incurred medical or remedial care expenses not subject to payment by a third party, specified section 1902(r)(1) of the Act:		
a. Health insurance premiums, deductibles and co-insurance charges.		
b. Necessary medical or remedial care expenses recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits that the State may establish on the amounts of these expenses. <i>Select one:</i>		
<input type="radio"/>	The State does not establish reasonable limits.	
<input type="radio"/>	The State uses the same reasonable limits as are used for regular (non-spousal) post-eligibility.	

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Appendix B-6: Evaluation/Reevaluation of Level of Care

As specified in 42 CFR §441.302(c), the State provides for an evaluation (and periodic reevaluations) of the need for the level(s) of care specified for this waiver, when there is a reasonable indication that an individual may need such services in the near future (one month or less), but for the availability of home and community-based waiver services.

- a. Reasonable Indication of Need for Services.** In order for an individual to be determined to need waiver services, an individual must require: (a) the provision of at least one waiver service, as documented in the service plan, and (b) the provision of waiver services at least monthly or, if the need for services is less than monthly, the participant requires regular monthly monitoring which must be documented in the service plan. Specify the State's policies concerning the reasonable indication of the need for waiver services:

i.	Minimum number of services. The minimum number of waiver services (one or more) that an individual must require in order to be determined to need waiver services is <i>(insert number)</i> :
	2
ii.	Frequency of services. The State requires <i>(select one)</i> :
	<input type="radio"/> The provision of waiver services at least monthly
	<input checked="" type="radio"/> Monthly monitoring of the individual when services are furnished on a less than monthly basis. If the State also requires a minimum frequency for the provision of waiver services other than monthly (e.g., quarterly), specify the frequency:
	We require case management monitoring a minimal of one per quarter.

- b. Responsibility for Performing Evaluations and Reevaluations.** Level of care evaluations and reevaluations are performed *(select one)*:

<input type="radio"/>	Directly by the Medicaid agency
<input type="radio"/>	By the operating agency specified in Appendix A
<input checked="" type="radio"/>	By an entity under contract with the Medicaid agency. <i>Specify the entity</i> :
	Dual Diagnosis Management
<input type="radio"/>	Other <i>(specify)</i> :

- c. Qualifications of Individuals Performing Initial Evaluation:** Per 42 CFR §441.303(c)(1), specify the educational/professional qualifications of individuals who perform the initial evaluation of level of care for waiver applicants:

Registered, Licensed Practical, or Licensed Vocational Nurse

- d. Level of Care Criteria.** Fully specify the level of care criteria that are used to evaluate and reevaluate whether an individual needs services through the waiver and that serve as the basis of the State's level of care instrument/tool. Specify the level of care instrument/tool that is employed. State laws, regulations, and policies concerning level of care criteria and the level of care instrument/tool are available to CMS upon request through the Medicaid agency or the operating agency (if applicable), including the instrument/tool utilized.

The level of care instrument used by the State is entitled the Level of Care (LOC) Determination form. The completed document must be approved by the Dual Diagnosis Management (DDM) to verify that the individual meets nursing facility level of care, as defined in North Dakota Administrative Code (N.D.A.C) 75-02-02-09.

The case manager gathers the information needed to complete the LOC Determination form. The case manager will complete the LOC Determination form and contact DDM. DDM makes a determination and forwards a copy of the determination response to the case manager and the Department.

The same process is required for initial or re-evaluations of level of care.

- e. Level of Care Instrument(s).** Per 42 CFR §441.303(c)(2), indicate whether the instrument/tool used to evaluate level of care for the waiver differs from the instrument/tool used to evaluate institutional level of care (*select one*):

<input checked="" type="radio"/>	The same instrument is used in determining the level of care for the waiver and for institutional care under the State Plan.
<input type="radio"/>	A different instrument is used to determine the level of care for the waiver than for institutional care under the State plan. Describe how and why this instrument differs from the form used to evaluate institutional level of care and explain how the outcome of the determination is reliable, valid, and fully comparable.

- f. Process for Level of Care Evaluation/Reevaluation.** Per 42 CFR §441.303(c)(1), describe the process for evaluating waiver applicants for their need for the level of care under the waiver. If the reevaluation process differs from the evaluation process, describe the differences:

Same as initial evaluation

- g. Reevaluation Schedule.** Per 42 CFR §441.303(c)(4), reevaluations of the level of care required by a participant are conducted no less frequently than annually according to the following schedule (*select one*):

<input type="radio"/>	Every three months
<input type="radio"/>	Every six months
<input checked="" type="radio"/>	Every twelve months
<input type="radio"/>	Other schedule (<i>specify</i>):

- h. Qualifications of Individuals Who Perform Reevaluations.** Specify the qualifications of individuals who perform reevaluations (*select one*):

<input checked="" type="radio"/>	The qualifications of individuals who perform reevaluations are the same as individuals who
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	perform initial evaluations.
○	The qualifications are different. The qualifications of individuals who perform reevaluations are (<i>specify</i>):

- i. **Procedures to Ensure Timely Reevaluations.** Per 42 CFR §441.303(c)(4), specify the procedures that the State employs to ensure timely reevaluations of level of care (*specify*):

Case Managers are responsible to retain a schedule of when re-evaluations are due. In addition, DDM generates a report to the Department and the appropriate case manager that lists those individuals whose re-evaluations will become due the following quarter.
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- j. **Maintenance of Evaluation/Reevaluation Records.** Per 42 CFR §441.303(c)(3), the State assures that written and/or electronically retrievable documentation of all evaluations and reevaluations are maintained for a minimum period of 3 years as required in 45 CFR §74.53. Specify the location(s) where records of evaluations and reevaluations of level of care are maintained:

Case Management Agencies retain copies of the instrument and approvals/denials of screenings. DDM retains records that are available to the Department.

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Appendix B-7: Freedom of Choice

Freedom of Choice. As provided in 42 CFR §441.302(d), when an individual is determined to be likely to require a level of care for this waiver, the individual or his or her legal representative is:

- i. informed of any feasible alternatives under the waiver; and
- ii. given the choice of either institutional or home and community-based services.

- a. **Procedures.** Specify the State's procedures for informing eligible individuals (or their legal representatives) of the feasible alternatives available under the waiver and allowing these individuals to choose either institutional or waiver services. Identify the form(s) that are employed to document freedom of choice. The form or forms are available to CMS upon request through the Medicaid agency or the operating agency (if applicable).

The State requires the Case Management Agency to obtain signatures of applicants/consumers or legal representatives on the following forms: Explanation of Client Choice SFN 1597; Application for Service SFN 1047; and the Individual Care Plan SFN 1467.

These documents allow the applicant/consumer or legal representative to indicate that they have agreed to choose Waiver services versus institutional care; that they have chosen their service provider(s), have accepted a plan of care; and that they have been informed of the right to appeal if dissatisfied or not in agreement with services.

- b. **Maintenance of Forms.** Per 45 CFR §74.53, written copies or electronically retrievable facsimiles of Freedom of Choice forms are maintained for a minimum of three years. Specify the locations where copies of these forms are maintained.

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Appendix B-8: Access to Services by Limited English Proficient Persons

Access to Services by Limited English Proficient Persons. Specify the methods that the State uses to provide meaningful access to the waiver by Limited English Proficient persons in accordance with the Department of Health and Human Services “Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons” (68 FR 47311 - August 8, 2003):

When a consumer is unable to independently communicate with a case manager or State reviewer, a family member or community interpreter is present.

The Department has a Limited English proficiency implementation plan that provides guidelines and resources.

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